R E P O R T R E S U M E S

ED 014 117 CG 001 024

THE MAJOR CONCEPTS TAUGHT TO BEHAVIOR THERAPY TRAINEES.

BY- ULLMANN, LEONARD P.

PUB DATE 1 SEP 67

EDRS PRICE MF-$0.25 HC-$0.68 15P.

DESCRIPTORS- SPEECHES, *TRAINING, BEHAVIOR THEORIES, *OPERANT CONDITIONING, *THERAPISTS, *BEHAVIOR,

SOME OF THE PROBLEMS IN ARRIVING AT A TRAINING PROGRAM FOR BEHAVIOR THERAPISTS STEM FROM THE DIFFICULTY IN DEFINING BEHAVIOR THERAPY. BASICALLY, HOWEVER, A PERSON'S DIFFICULTY IS UNDERSTOOD AS HIS BEHAVIOR IN REACTION TO SITUATIONS. THIS BEHAVIOR RESULTS FROM A CURRENT OR PREVIOUS REINFORCER. NORMAL AND ABNORMAL BEHAVIOR DIFFER ONLY IN THE TERMS OF THE EVALUATIVE CRITERIA USED. THE BEHAVIOR THERAPY TRAINEE MUST LEARN A NEW VIEW OF PEOPLE. HE MUST VIEW THE TARGET BEHAVIOR AS A NORMAL, APPROPRIATE, AND REASONABLE OUTCOME OF PAST AND CONTINUING EXPERIENCE. THE TRAINEE MUST EXAMINE PEOPLE AND THEIR ACTIONS, THE CONDITIONS ELICITING THEIR BEHAVIORS, AND ALTERNATIVE BEHAVIORS. SINCE THE TARGET BEHAVIOR IS CONSIDERED A RESULT OF LEARNING, IT MUST BE DEALT WITH IN A SITUATION AS CLOSE AS POSSIBLE TO THE TARGET. THIS MAY REQUIRE PARENTS, TEACHERS, OR PEERS AS REINFORCERS. THE WIDE VARIETY OF PEOPLE INVOLVED IN BEHAVIOR THERAPY HAS TWO MAJOR IMPLICATIONS FOR THE PSYCHOLOGIST. HE MUST TEACH PRINCIPLES AND PROGRAM AN ENVIRONMENT. NO INVARIANT SET OF BEHAVIORS CAN BE USED. THE BEHAVIOR THERAPIST MUST BE TRAINED TO TAKE AN ACTIVE ROLE, TO MAKE VALUE JUDGMENTS, AND TO EXAMINE HIMSELF. THIS PAPER WAS PRESENTED AT THE AMERICAN PSYCHOLOGICAL ASSOCIATION CONVENTION, WASHINGTON, D.C., SEPTEMBER 1, 1967. (SK)

ED014117

Paper read at Convention of the American Psychological Association, Washington, D. C., September 1, 1967 as part of a symposium on "Training Behavior Therapists."

The Major Concepts Taught to Behavior Therapy Trainees

Leonard P. Ullmann
University of Illinois

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

CG 001 024

In talking about the training of behavior therapists, the first requirement is to define behavior therapy. This is not easy. The very composition of the present group of dirty old symposiasts illustrates that behavior therapy is not a single homogeneous doctrine. I think it is fair to say that Dr. Ayllon and I lean toward an operant and Skinnerian approach as much as Drs. Wolpe and Franks lean toward a Pavlovian and neo-Hullian model. Dr. Wolpe in his new book with Arnold Lazarus (1966) says some things about psychotics which I find inconsistent with work such as that by Lovaas et.al. (1965, 1966) and by Graziano & Kean with autistic children and work with adult psychotics such as that by Ayllon and Azrin (1965) and Atthowe and Krasner (in press). Such differences, however, do not detract from behavior therapists. The point simply is that behavior therapy is not a pure school or pure social movement, and let us hope it never will be.

What binds behavior therapists together is that they seek to alter by direct rather than indirect methods behavior that the person himself or some significant other wishes to change. In this regard there are elements of behavior therapy in the writings of people as diverse as Albert Ellis, Hobart Mowrer, Alfred Adler, George Kelly, and Dale Carnegie. I know of no behavior therapist, even one as flexible as myself, who will accept as true everything every other behavior therapist suggests. But the basic orientation is that the person's difficulty is his behavior in reaction to situations, and that this behavior is the result of previous and current reinforcing stimuli and is not symptomatic of some deeper, underlying discontinuity with normal functioning that must be dealt with prior to the emitted behavior.

One of the implications of the behavioral view is that there is no distinction between normal and abnormal other than as behavior is evaluated by criteria which change over time, over place, and over persons.

In operation, the social character of abnormal behavior is well recognized. Glasscote et. al. (1966, p. 11) make the point as follows: "... classification as a psychiatric emergency seems largely contingent on one's being conceived of as a social emergency." Jay Jackson (1964, p.45) puts it this way: "It is unlikely that people are very often committed to state mental hospitals solely because they are unhappy or suffering; most often they are committed only when their behavior is such that they impose inconvenience, embarrassment, or suffering upon others. Thus, although the diagnostic categories employed may be psychiatric, the symptoms from which illness is inferred relate to social behavior." Once in the hospital a person is treated for a disease and regardless of the change in his behavior; it is this disease that justifies both his incarceration and his release.

This leads me to a general point and one I've long wished to make in public. McDougall (cited in Reisman 1966, p. 148) once described Watson as follows: "Thus, by repudiating one half of the methods of psychology and resolutely shutting his eyes to three quarters of its problems, he laid down the program of Behaviorism and rallied to its standard all those who have a natural distaste for difficult problems and a preference for short, easy, and fictitious solutions."

An echo of this thundering indictment is a recent whimper: "The Skinnerian group...have no special theory of neurosis...Their approach rests heavily on techniques of operant conditioning, on the use of 'reinforcement' to control and shape behavior, and on the related notion that 'symptoms,' like all other 'behaviors,' are maintained by their effects." (Breger & McGaugh, 1965). Other than the bitchy quotation marks, the statement is accurate.

The issue is whether a theory is needed, even one full of words and scholarship, if it signifies nothing. Another way of saying this is that

the Emperor has no clothes, that bedtime troubles do not arise from incubi and succubi, but good old fashioned sex, and that symptom substitution is a thoroughly discredited hypothesis. Granted, if we deprived ourselves of the notion of mental illnesses we would loose a lot of articles on the differences between middle-aged hospitalized males called schizophrenics and college sophomores, both groups treated exactly the same because the work is so very scientific. But I have faith that there are sufficient reinforcers for publication that something else would soon fill the pages of our journals.

The Freudian has a view of symptom formation as the solution of an intrapsychic conflict and a basically pessimistic concept of man. The Rogerian view is of man as basically good, growing, and striving for self-actualization. Both these views have basic drives which are blocked and distorted; both see the therapist as a sort of passive midwife who helps without being responsible and who, with minor variations, always does the same thing. The ultimate of this formulation is the promulgation that the necessary and sufficient condition for therapeutic change is the establishment of a warm, non-evaluative relationship. All one has to do is be nice if one is a Rogerian, or expensive if a Freudian, and just wait around for a cure.

The behavioral alternative is to discard the concept of abnormality. Further, man is neither good nor bad; the assumption is made that he is alive, and he is what he learns to be. Therefore the behavior therapist is both active and responsible, and he is so in terms of individuals and not a process.

The first thing a behavior therapy trainee then must learn is a new view of people. This means that the target behavior is a normal, appropriate, reasonable outcome of past and continuing experience. This is a very

therapeutic thing in and of itself. It leads the behavior therapist to address his client as a normal individual and one to be respected for the strengths he manifests in the majority of his activities. Such strengths are not defenses or reaction formations. The person's difficulties are not the outgrowth of his totally distorted psyche and are not the result of a compromise between intrapsychic conflicts. The person is a unique person and not a label or a diagnostic categorization. Specifically, we no longer deal with phobics who require a total overhaul, but with people who under limited and specifiable circumstances emit phobic behavior. We deal with responses to those circumstances, and we do not use peoples' occasional phobic responses to justify an excursion into their unconsciouses.

If people still want abstractions and formulations of abnormality, all human behavior, especially normal acts, become adequate models. For example, I think that anyone who can explain how a college girl comes to emit such biologically implausible behavior as maintaining her virginity, or who can explain how a decent college boy comes to drop jellied gas on civilians has a perfect model for such utterly sick behaviors as sitting on a chair staring at a wall, failure of a New Yorker to assert himself, or that ultimate of vile behavior, drinking too much at an APA convention. Looking at behavior, truly there is nothing as far out as a square and nothing as bizarre as a rule abiding mid twentieth century American.

We want behavior therapy trainees to look at people and what they are doing. The key is the word <u>what</u>. In evaluating a situation, the behavior therapist must shift from the traditional <u>why</u> questions to <u>what</u> questions. He must ask <u>what</u> is the person doing. He must ask under <u>what</u> conditions are these behaviors emitted. He must ask <u>what</u> are the effects of these acts, <u>what</u> changes occur after they are emitted. He must ask <u>what</u> other behaviors

might the person emit. He asks this last question in terms of <u>what</u> actions may have been extinguished, <u>what</u> situations are being avoided, and <u>what</u> acts may be encouraged or shaped up. He asks <u>what</u> reinforcers can be applied, <u>what</u> reinforcers can other interested people bring to bear in a response contingent manner. He asks <u>what</u> needs to be done to have nurses, parents, teachers,or the patient himself follow through with the emission, reinforcement, and recognition of behavior change. Both the patient and his therapists must be able to spot the right time and place for emitting an act, they must be capable of emitting the act, that is, have it in their repertoires, and they must actually emit it. If these requirements are not met, the act will not be reinforced. All the insight and desire in the world will do no good if the person does not know when and how to emit the needed operants. Ambrose Bierce defines "abduction" as "a species of invitation without persuasion." Our task very often is to teach subjects--whether we call them patients, parents, teachers, or therapists--effective ways of persuading other members of the population. The behavior therapist does only a fraction of his job when he reduces the emission of a deviant response; he does his most important work when he teaches the person to emit the appropriate response to the situation.

Insight makes little difference if the person does not know how to act differently. If you have a Freudian or Rogerian model, trouble is a detour on the grand road of normal behavior; but if you are a behavior therapist you must take into account that the person may be all raring to go and not have the act in his repertoire. I also think that insight probably follows rather than precedes changed behavior. To quote Franz Alexander (Alexander and French, 1946, p. 40): "Like the adage 'Nothing succeeds like success,' there is no more powerful therapeutic factor than the performance of activities which were formerly neurotically impaired or inhibited. No insight no

emotional discharge, no recollection can be as reassuring as accomplishment in the actual life situation in which the individual failed. Thus the ego regains that confidence which is the fundamental condition, the prerequisite, of mental health. Every success encourages new trials and decreases inferiority feelings, resentments, and their sequelae--fear, guilt, and resulting inhibitions. Successful attempts at productive work, love, self-assertion, or competition will change the vicious circle to a benign one; as they are repeated, they become habitual and thus eventually bring about a complete change in the personality."

We want the person to be different. We ask <u>what</u> questions and this leads us to answers that are overt, measurable, and manipulatable behaviors. Asking the right questions is something that is crucial in the training of a behavior therapist.

The asking of what questions may be contrasted with the asking of why questions. The matter at a clinical level was put into a nutshell by Eric Berne (1964, p. 19) when he wrote: "Experience has shown that it is more useful and enlightening to investigate social transactions from the point of view of the advantages gained than to treat them as defensive operations." We are advocating the what, the advantages gained. If one asks why, the motivation or the defense, one enters an endless regress. Every behavior therapist has his own favorite hideous example. Mine is family therapy of schizophrenics (Bowen, 1960) in which parents are made to live on the wards with their "sick" children.

For brevity, however, here is the abstract of an article on "The truth as resistance to free association": "The truth is often a reaction formation while lies represent the despised fecal product which the patient has consciously learned to abhor but unconsciously is still so attracted to that

his tendency to lie cannot be permitted into consciousness. It might be conjectured that free association represents the polymorphous perverse activity of a child which at one time was all-pervasive and ego-syntonic." (Prager, 1967, p. 460) This quotation does not have the faults McDougall found in Watson; if anything it adds vastly to the problems, methods, and difficulties of psychology.

Having stripped himself of some of the myths and having learned to ask useful questions, the next locus for the behavior therapist is altering behavior. Since the behavior is considered the result of learning rather than some symptom, it may be changed directly. This implies that the behavior will be dealt with in a situation as close to the target as possible. As such, teachers, nurses, spouses, friends, parents, and fellow pupils may be programmed to provide conditions in which new and more desirable behaviors will be emitted and reinforced. Examples of the training of teachers in behavioral techniques have been provided by Zimmerman and Zimmerman (1962) Wolf, et. al. (1965), O'Leary and Becker (1967); Ayllon and Michael (1959) have focused on the role of the nurse as a behavioral engineer; spouses play a crucial role in situations such as the treatment of impotence (Wolpe, 1958) and frigidity (Madsen & Ullmann, 1967); friends have been enlisted in the treatment of excessive drinking (Sulzer, 1965); parents have been trained to identify and differentially reinforce problem behavior in their children (Bijou, 1965; Whaler et.al., 1965; Hawkins et.al. 1966) and to extend therapeutic efforts to ameliorate difficulties such as stuttering (Rickard & Mundy, 1965); and fellow pupils have themselves been placed under such reinforcement contingencies that they will reinforce a fellow pupil's more adaptive behavior where previously it had provided a source of novelty in the midst of classroom boredome (Patterson, 1965). Finally, whether by

chaining, self-reinforcement, emission of relaxation responses, or simply applying learning concepts such as extinction, the person himself may alter his own environment.

The wide range of people who are involved in behavior therapy has two implications. The first is that the psychologist's role as consultant shifts drastically from a focus on a particular case to the teaching of principles and programming of the environment. The second implication is that no invariant set of concepts is used. The focus in consultation is similar to the focus in treatment: to obtain changed behavior. The psychologist will therefore select and present his concepts in terms of what is serviceable for the person with whom he works rather than in terms of a "course" which must be completed.

The first point to be made is that when we talk of training behavior therapists, we talk of garden variety normal people and are not restricted to that deviant group known as clinical psychology graduate students. The same what questions asked in determining the course of action with the patient are asked in determining the course of action with parents, teachers, spouses, and nurses. Until the psychologist is clear as to his own program there is no reason to expect that other people will do what he considers desirable. Once the course of action has been decided upon the specifics for training the therapists are no different from the specifics of training patients: both are normal people.

The literature on the cooperation and change of significant others is steadily growing. What would be said of them can be said of the therapist's major ally, the patient. Under what conditions will a person do what another suggests? In this regard, as Wolpe and Lazarus (1966, p.28) point out, the establishment of a relationship is a necessary first step. The attitudes

discussed earlier are a great step forward in achieving a relationship which indicates understanding and respect (without dependence) for the patient. The next step is that cues are given in the language and at the rate which the patient can use. If desensitization is to proceed the patient must know how to relax, how to visualize, and when and how to signal an increase in tension. If a person is to model, the model's actions must be as clear as the consequences of that activity. All the modeling in the world will do no good if the person does not attend or does not have the skill being modelled in his repertoire. The behavior therapist must make an analysis of what is most likely to be effective. This program is put to the test, and every behavioral technique for altering patients is appropriate for the training of behavior therapists. Selective response contingent reinforcement, records of changes, explicit statements of reinforcing contingencies, prompts and their fading, and so on, are used. The patient may keep records of his own behavior or provide himself with an aversive shock, not only in the treatment session, but as he moves throughout his daily life. To hearken back to the quotation from Alexander, the effective reinforcer for both patient and behavior therapist is new successful behavior. The behavior therapist uses every possible pedagogic device feasible to foster the new behavior, but once established and successful it is maintained because it works. There is little difficulty with termination or transference because of the therapist's attitude toward the patient, because the domain of discourse is real extra-therapy behavior, and because what is learned is not a relationship to the therapist but methods of dealing with people. These methods when successful not only are maintained, but like other behaviors that work, are generalized.

The concepts taught to behavior therapists about themselves parallel most closely the role of teacher. The techniques and principles are those of social learning and behavior influence. I will not review them other than to say that simply handing out tokens does not mean a person has a token economy; and shocking a person contingent upon some behavior does not mean a person is a behavior therapist. To say this is equivalent to saying that anybody who runs rats is an experimenter. In both instances it is the design of the situation and not the implementation that is a crucial element.

The role is active. The behavior therapist assumes responsibility; he is not midwife to a process but involved in the specific behaviors attempted and the conditions under which the person lives. This is the exact opposite of Szasz's formulation of psychotherapy as a "game" divorced from reality. Treatment deals with real behavior and has its goal change in extra therapy situations. The behavior therapist must be ready to accept this active responsible role. I find that parents, teachers, nursing personnel, spouses and friends, rather than being sick as so much of the psychoanalytic literature pictures them, are actively interested in the patient. It is a source of gratification to find how quickly people not overly tainted by college courses or Ann Landers will delay their own gratifications in order to help another person. I think the reason for this favorable response to behavior therapy is that it makes sense because it is how normal people act toward each other.

There is one additional point for the professional behavior therapist: he must be prepared to make value judgments. Such judgments are inherent in the view that there is no behavior that is "sick" in and of itself. A whole range of decisions arise which did not exist when all deviant behavior was presumed to exist as a malfunctioning of the intrapsychic

apparatus. In operation the therapist may decide on courses of action that would horrify the Dean of Students or the local minister. There are also times when the behavior therapist will arrange reinforcement contingencies in a manner that will lead to adjustment or conformity to such repressive forces as a child's parents or the orderly progress of classroom tuition. The point is that value problems cannot be forced aside by merely calling a behavior sick. The behavior therapist must look at the specific situation and work with an individual not a disease label.

Techniques seem easy to apply and those who have little experience with behavior therapy think that one simply tells people what to do or simply gives shocks at one time and candy at another. Nothing could be further from the truth. By focusing on individual behavior many concepts and many words have been found to be unnecessary and even malicious obstacles between the psychologist and his patient. But these concepts made life much easier because they provided high-sounding words to bury problems. The behavior therapist in training others, whether they be patients or significant others, must constantly check what he himself is doing. It is very much the examined and the examining life.

While a lot of words drop out, behavior therapy is far from barren and mechanistic. Quite the contrary, for a person can no longer say he loves, empathizes, relates or does other good things. Behavior therapy asks, not what is the reason, but what is the action.

In summary, the behavior therapist must be taught new ways of looking at people. The people he works with are neither sick nor healthy, but simply behavior emitting human beings. The same principles apply to training patients and therapists. The crucial element lies in the asking of questions likely to elicit explicit behavioral referents: that is, the asking of <u>what</u>

questions rather than <u>why</u> questions. One result of this approach is that a great deal of theory about "sick" people becomes irrelevant other than in journals and on doctoral exams. A second result is that the behavior therapist assumes far greater responsibility than the typical mid-wife-to-a-process therapist. The behavior therapist is a real person dealing with other real people. And this, I think, is the theoretical, moral, and practical crux of training behavior therapists, whether those therapists are called psychologists, parents, or attendants. There is a pressure away from words and the labeling of motives and a movement towards the actual behaviors and operations. The result is demonstrably more effective in obtaining behavior change. Above all, the result is an active, responsible, and genuine engagement, not with abstractions, but with other people.

References

Alexander, F., & French, T. M. Psychoanalytic Therapy. New York: Ronald, 1946

Atthowe, J. M., Jr., & Krasner, L. A preliminary report on the application of contingent reinforcement procedures (token economy) on a "chronic" psychiatric ward. Journal of Abnormal Psychology, in press.

Ayllon, T., & Azrin, N. H. The measurement and reinforcement of behavior of psychotics. Journal of the Experimental Analysis of Behavior, 1965, 8, 357-384.

Ayllon, T., & Michael, J. The psychiatric nurse as a behavioral engineer. Journal of the Experimental Analysis of Behavior, 1959, 2, 323-334.

Berne, E. Games People Play. New York: Grove Press, 1964.

Bijou, S. W. Experimental studies of child behavior, normal and deviant. In, L. Krasner, & L. P. Ullmann (Eds.) Research in Behavior Modification New York: Holt, Rinehart, & Winston, 1965, 56-81.

Bowen, M. A family concept of schizophrenia. In, D. D. Jackson (Ed.) The Etiology of Schizophrenia. New York: Basic Books, 1960, 346-372.

Breger, L., & McGaugh, J. L. Critique and reformulation of "Learning-theory" approaches to psychotherapy and neurosis. Psychological Bulletin, 1965, 63, 338-358.

Glasscote, R. M., Cumming, E., Hammersley, D. W., Ozarin, L. D., & Smith, L.H. The Psychiatric Emergency. Washington, D.C.: Joint Information Service, 1966.

Graziano, A. M., & Kean, J. E. Programmed relaxation and reciprocal inhibition with psychotic children. Proceedings of the 75th Annual APA Convention, 1967, pp. 253-254.

Hawkins, R. P., Peterson, R. F., Schweid, E., & Bijou, S. W. Behavior therapy in the home: Amelioration of problem parent-child relations with the parent in a therapeutic role. Journal of Experimental Child Psychology, 1966, 4, 99-107.

Jackson, J. Toward the comparative study of kental hospitals: Characteristics of the treatment environment. In, A. F. Wessen (Ed.) The Psychiatric Hospital as a Social System. Springfield, Ill.: Thomas, 1964, 35-87.

Lovaas, O. I., Freitag, G., Kinder, M. I., Rubenstein, B. D., Schaeffer, B., & Simmons, J. Q. Establishment of social reinforcers in two schizophrenic children on the basis of food. Journal of Experimental Child Psychology, 1966, 4, 109-125.

Lovaas, O. I., Schaeffer, B. M., & Simmons, J. Q. Building social behavior in autistic children by use of electric shock. Journal of Experimental Research in Personality, 1965, 1, 99-109.

Madsen, C. H., Jr., & Ullmann, L. P. Innovations in the desensitization of frigidity. Behaviour Research and Therapy, 1967, 5, 67-68.

O'Leary, K. D., & Becker, W. C. Behavior modification of an adjustment class: A token reinforcement program. Exceptional Children, 1967, 33, 637-642.

Patterson, G. H. An application of conditioning techniques to the control of a hyperactive child. In, L. P. Ullmann & L. Krasner (Eds.) Case Studies in Behavior Modification. New York: Holt, Rinehart, Winston, 1965, 370-375.

Prager, D. Abstract of H. R. Stern: The truth as a resistance to free association. Psychological Abstracts, 1967, 41, 460 (#4740).

Reisman, J. M. The Development of Clinical Psychology. New York: Appleton-Century-Crofts, 1966.

Rickard, H. C., & Mundy, M. B. Direct manipulation of stuttering behavior: An experimental-clinical approach. In, L. P. Ullmann & L. Krasner (Eds.) Case Studies in Behavior Modification. New York: Holt, Rinehart, & Winston, 1965, 268-274.

Sulzer, E. S. Behavior modification in adult psychiatric patients. In, L. P. Ullmann, & L. Krasner (Eds.) Case Studies in Behavior Modification. New York: Holt, Rinehart, Winston, 1965, 196-200.

Whaler, R. G., Winkel, G. H., Peterson, R. F., & Morrison, D. C. Mothers as behavior therapists for their own children. Behaviour Research and Therapy, 1965, 3, 113-124.

Wolf, M. M., Birnbrauer, J. S., Williams, R., & Lawler, J. A note on apparent extinction of the vomiting behavior of a retarded child. In, L. P. Ullmann & L, Krasner (Eds.) Case Studies in Behavior Modification. New York: Holt, Rinehart, Winston, 1965, 364-366.

Wolpe, J. Psychotherapy by Reciprocal Inhibition. Stanford University Press, 1967.

Wolpe, J., & Lazarus, A. A. Behavior Therapy Techniques. Oxford: Pergamon Press, 1966.

Zimmerman, E. H., & Zimmerman, J. The alteration of behavior in a special classroom situation. Journal of Experimental Analysis of Behavior, 1962, 5, 59-60.